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I

106TH CONGRESS
1ST SESSION

H. R. 1285

To amend the Employee Retirement Income Security Act of 1974, Public Health Service Act, and the Internal Revenue Code of 1986 to require that group and individual health insurance coverage and group health plans provide coverage of cancer screening.

IN THE HOUSE OF REPRESENTATIVES

MARCH 25, 1999

Mrs. MALONEY of New York (for herself, Mrs. KELLY, Mr. RANGEL, Mr. MATSUI, Mr. GILMAN, Mrs. MINK of Hawaii, Mrs. MORELLA, Ms. SCHAKOWSKY, Mr. FROST, Mr. LANTOS, Mr. GUTIERREZ, Mr. CROWLEY, Mr. CUMMINGS, and Mr. SANDLIN) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committees on Education and the Workforce, and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend the Employee Retirement Income Security Act of 1974, Public Health Service Act, and the Internal Revenue Code of 1986 to require that group and individual health insurance coverage and group health plans provide coverage of cancer screening.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Cancer Screening Cov-
3 erage Act of 1999”.

4 **SEC. 2. CANCER SCREENING COVERAGE.**

5 (a) GROUP HEALTH PLANS.—

6 (1) PUBLIC HEALTH SERVICE ACT AMEND-
7 MENTS.—(A) Subpart 2 of part A of title XXVII of
8 the Public Health Service Act is amended by adding
9 at the end the following new section:

10 **“SEC. 2707. COVERAGE OF CANCER SCREENING.**

11 “(a) REQUIREMENT.—A group health plan, and a
12 health insurance issuer offering group health insurance
13 coverage, shall provide coverage and payment under the
14 plan or coverage for the following items and services under
15 terms and conditions that are no less favorable than the
16 terms and conditions applicable to other screening benefits
17 otherwise provided under the plan or coverage:

18 “(1) MAMMOGRAMS.—In the case of a female
19 participant or beneficiary who is 40 years of age or
20 older, or is under 40 years of age but is at high risk
21 (as defined in subsection (e)) of developing breast
22 cancer, an annual mammography (as defined in sec-
23 tion 1861(jj) of the Social Security Act) conducted
24 by a facility that has a certificate (or provisional cer-
25 tificate) issued under section 354 of the Public
26 Health Service Act.

1 “(2) CLINICAL BREAST EXAMINATIONS.—In the
2 case of a female participant or beneficiary who—

3 “(A)(i) is 40 years of age or older or (ii)
4 is at least 20 (but less than 40) years of age
5 and is at high risk of developing breast cancer,
6 an annual clinical breast examination; or

7 “(B) is at least 20, but less than 40, years
8 of age and who is not at high risk of developing
9 breast cancer, a clinical breast examination
10 each 3 years.

11 “(3) PAP TESTS AND PELVIC EXAMINATIONS.—
12 In the case of a female participant or beneficiary
13 who is 18 years of age or older, or who is under 18
14 years of age and is or has been sexually active—

15 “(A) an annual diagnostic laboratory test
16 (popularly known as a ‘pap smear’) consisting
17 of a routine exfoliative cytology test (Papani-
18 colaou test) provided to a woman for the pur-
19 pose of early detection of cervical or vaginal
20 cancer and including an interpretation by a
21 qualified health professional of the results of
22 the test; and

23 “(B) an annual pelvic examination.

24 “(4) COLORECTAL CANCER SCREENING PROCE-
25 DURES.—In the case of a participant or beneficiary

1 who is 50 years of age or older, or who is under 50
2 years of age and is at high risk of developing
3 colorectal cancer, all of the following procedures fur-
4 nished to the individual for the purpose of early de-
5 tection of colorectal cancer:

6 “(A) Screening fecal-occult blood test, but
7 not to exceed once every 12 months.

8 “(B) Screening flexible sigmoidoscopy, but
9 not to exceed once every 48 months.

10 “(C) In the case of an individual at high
11 risk for colorectal cancer, screening
12 colonoscopy, but not to exceed once every 24
13 months.

14 “(D) Such other tests or procedures, and
15 modifications to tests and procedures under this
16 paragraph, with such frequency, as the Sec-
17 retary determines appropriate, in consultation
18 with appropriate organizations.

19 Under this paragraph, a screening barium enema
20 may be substituted either for a screening flexible
21 sigmoidoscopy or for a screen colonoscopy at the at-
22 tending physician’s discretion.

23 “(5) PROSTATE CANCER SCREENING.—In the
24 case of a participant or beneficiary who is 50 years
25 of age or older, an annual test consisting of any (or

1 all) of the procedures described in section
2 1861(oo)(2) of Social Security Act (42 U.S.C.
3 1395x(oo)(2)) provided for the purpose of early de-
4 tection of prostate cancer.

5 “(b) PROHIBITIONS.—A group health plan, and a
6 health insurance issuer offering group health insurance
7 coverage in connection with a group health plan, may
8 not—

9 “(1) deny to an individual eligibility, or contin-
10 ued eligibility, to enroll or to renew coverage under
11 the terms of the plan, solely for the purpose of
12 avoiding the requirements of this section;

13 “(2) provide monetary payments or rebates to
14 individuals to encourage such individuals to accept
15 less than the minimum protections available under
16 this section;

17 “(3) penalize or otherwise reduce or limit the
18 reimbursement of a provider because such provider
19 provided care to an individual participant or bene-
20 ficiary in accordance with this section; or

21 “(4) provide incentives (monetary or otherwise)
22 to a provider to induce such provider to provide care
23 to an individual participant or beneficiary in a man-
24 ner inconsistent with this section.

25 “(c) RULES OF CONSTRUCTION.—

1 “(1) Nothing in this section shall be construed
2 to require an individual who is a participant or bene-
3 ficiary to undergo a procedure, examination, or test
4 described in subsection (a).

5 “(2) Nothing in this section shall be construed
6 as preventing a group health plan or issuer from im-
7 posing deductibles, coinsurance, or other cost-shar-
8 ing in relation to benefits described in subsection (a)
9 consistent with such subsection, except that such co-
10 insurance or other cost-sharing shall not discrimi-
11 nate on any basis related to the coverage required
12 under this section.

13 “(d) NOTICE.—A group health plan under this part
14 shall comply with the notice requirement under section
15 714(d) of the Employee Retirement Income Security Act
16 of 1974 with respect to the requirements of this section
17 as if such section applied to such plan.

18 “(e) HIGH RISK DEFINED.—For purposes of this
19 section, an individual is considered to be at ‘high risk’ of
20 developing a particular type of cancer if, under guidelines
21 developed or recognized by the Secretary based upon sci-
22 entific evidence, the individual—

23 “(1) has one or more close family members who
24 have developed that type of cancer;

25 “(2) has previously had that type of cancer;

1 “(3) has the presence of an appropriate recog-
 2 nized gene marker that is identified as putting the
 3 individual at a higher risk of developing that type of
 4 cancer; or

5 “(4) has other predisposing factors that signifi-
 6 cantly increases the risk of the individual con-
 7 tracting that type of cancer.

8 For purposes of this subsection, the term ‘type of cancer’
 9 includes other types of cancer that the Secretary recog-
 10 nizes as closely related for purposes of establishing risk.”.

11 (B) Section 2723(c) of such Act (42 U.S.C.
 12 300gg-23(c)) is amended by striking “section 2704”
 13 and inserting “sections 2704 and 2707”.

14 (2) ERISA AMENDMENTS.—(A) Subpart B of
 15 part 7 of subtitle B of title I of the Employee Re-
 16 tirement Income Security Act of 1974 is amended by
 17 adding at the end the following new section:

18 **“SEC. 714. COVERAGE OF CANCER SCREENING.**

19 “(a) REQUIREMENT.—A group health plan, and a
 20 health insurance issuer offering group health insurance
 21 coverage, shall provide coverage and payment under the
 22 plan or coverage for the following items and services under
 23 terms and conditions that are no less favorable than the
 24 terms and conditions applicable to other screening benefits
 25 otherwise provided under the plan or coverage:

1 “(1) MAMMOGRAMS.—In the case of a female
2 participant or beneficiary who is 40 years of age or
3 older, or is under 40 years of age but is at high risk
4 (as defined in subsection (e)) of developing breast
5 cancer, an annual mammography (as defined in sec-
6 tion 1861(jj) of the Social Security Act) conducted
7 by a facility that has a certificate (or provisional cer-
8 tificate) issued under section 354 of the Public
9 Health Service Act.

10 “(2) CLINICAL BREAST EXAMINATIONS.—In the
11 case of a female participant or beneficiary who—

12 “(A)(i) is 40 years of age or older or (ii)
13 is at least 20 (but less than 40) years of age
14 and is at high risk of developing breast cancer,
15 an annual clinical breast examination; or

16 “(B) is at least 20, but less than 40, years
17 of age and who is not at high risk of developing
18 breast cancer, a clinical breast examination
19 each 3 years.

20 “(3) PAP TESTS AND PELVIC EXAMINATIONS.—
21 In the case of a female participant or beneficiary
22 who is 18 years of age or older, or who is under 18
23 years of age and is or has been sexually active—

24 “(A) an annual diagnostic laboratory test
25 (popularly known as a ‘pap smear’) consisting

1 of a routine exfoliative cytology test (Papanicolaou test) provided to a woman for the purpose of early detection of cervical or vaginal cancer and including an interpretation by a qualified health professional of the results of the test; and

7 “(B) an annual pelvic examination.

8 “(4) COLORECTAL CANCER SCREENING PROCEDURES.—In the case of a participant or beneficiary who is 50 years of age or older, or who is under 50 years of age and is at high risk of developing colorectal cancer, all of the following procedures furnished to the individual for the purpose of early detection of colorectal cancer:

15 “(A) Screening fecal-occult blood test, but not to exceed once every 12 months.

17 “(B) Screening flexible sigmoidoscopy, but not to exceed once every 48 months.

19 “(C) In the case of an individual at high risk for colorectal cancer, screening colonoscopy, but not to exceed once every 24 months.

23 “(D) Such other tests or procedures, and modifications to tests and procedures under this paragraph, with such frequency, as the Sec-

1 retary of Health and Human Services deter-
2 mines appropriate, in consultation with appro-
3 priate organizations.

4 Under this paragraph, a screening barium enema
5 may be substituted either for a screening flexible
6 sigmoidoscopy or for a screen colonoscopy at the at-
7 tending physician's discretion.

8 “(5) PROSTATE CANCER SCREENING.—In the
9 case of a participant or beneficiary who is 50 years
10 of age or older, an annual test consisting of any (or
11 all) of the procedures described in section
12 1861(oo)(2) of Social Security Act (42 U.S.C.
13 1395x(oo)(2)) provided for the purpose of early de-
14 tection of prostate cancer.

15 “(b) PROHIBITIONS.—A group health plan, and a
16 health insurance issuer offering group health insurance
17 coverage in connection with a group health plan, may
18 not—

19 “(1) deny to an individual eligibility, or contin-
20 ued eligibility, to enroll or to renew coverage under
21 the terms of the plan, solely for the purpose of
22 avoiding the requirements of this section;

23 “(2) provide monetary payments or rebates to
24 individuals to encourage such individuals to accept

1 less than the minimum protections available under
2 this section;

3 “(3) penalize or otherwise reduce or limit the
4 reimbursement of a provider because such provider
5 provided care to an individual participant or bene-
6 ficiary in accordance with this section; or

7 “(4) provide incentives (monetary or otherwise)
8 to a provider to induce such provider to provide care
9 to an individual participant or beneficiary in a man-
10 ner inconsistent with this section.

11 “(c) RULES OF CONSTRUCTION.—

12 “(1) Nothing in this section shall be construed
13 to require an individual who is a participant or bene-
14 ficiary to undergo a procedure, examination, or test
15 described in subsection (a).

16 “(2) Nothing in this section shall be construed
17 as preventing a group health plan or issuer from im-
18 posing deductibles, coinsurance, or other cost-shar-
19 ing in relation to benefits described in subsection (a)
20 consistent with such subsection, except that such co-
21 insurance or other cost-sharing shall not discrimi-
22 nate on any basis related to the coverage required
23 under this section.

24 “(d) NOTICE UNDER GROUP HEALTH PLAN.—The
25 imposition of the requirement of this section shall be treat-

1 ed as a material modification in the terms of the plan de-
2 scribed in section 102(a)(1), for purposes of assuring no-
3 tice of such requirements under the plan; except that the
4 summary description required to be provided under the
5 last sentence of section 104(b)(1) with respect to such
6 modification shall be provided by not later than 60 days
7 after the first day of the first plan year in which such
8 requirement apply.

9 “(e) HIGH RISK DEFINED.—For purposes of this
10 section, an individual is considered to be at ‘high risk’ of
11 developing a particular type of cancer if, under guidelines
12 developed or recognized by the Secretary based upon sci-
13 entific evidence, the individual—

14 “(1) has one or more close family members who
15 have developed that type of cancer;

16 “(2) has previously had that type of cancer;

17 “(3) has the presence of an appropriate recog-
18 nized gene marker that is identified as putting the
19 individual at a higher risk of developing that type of
20 cancer; or

21 “(4) has other predisposing factors that signifi-
22 cantly increases the risk of the individual con-
23 tracting that type of cancer.

1 For purposes of this subsection, the term ‘type of cancer’
 2 includes other types of cancer that the Secretary recog-
 3 nizes as closely related for purposes of establishing risk.”.

4 (B) Section 731(c) of such Act (29 U.S.C.
 5 1191(c)) is amended by striking “section 711” and
 6 inserting “sections 711 and 714”.

7 (C) Section 732(a) of such Act (29 U.S.C.
 8 1191a(a)) is amended by striking “section 711” and
 9 inserting “sections 711 and 714”.

10 (D) The table of contents in section 1 of such
 11 Act is amended by inserting after the item relating
 12 to section 713 the following new item:

“Sec. 714. Coverage of cancer screening.”.

13 (3) INTERNAL REVENUE CODE AMEND-
 14 MENTS.—Subchapter B of chapter 100 of the Inter-
 15 nal Revenue Code of 1986 is amended—

16 (A) in the table of sections, by inserting
 17 after the item relating to section 9812 the fol-
 18 lowing new item:

“Sec. 9813. Coverage of cancer screening.”; and

19 (B) by inserting after section 9812 the fol-
 20 lowing:

21 **“SEC. 9813. COVERAGE OF CANCER SCREENING.**

22 “(a) REQUIREMENT.—A group health plan shall pro-
 23 vide coverage and payment under the plan for the fol-
 24 lowing items and services under terms and conditions that

1 are no less favorable than the terms and conditions appli-
2 cable to other screening benefits otherwise provided under
3 the plan:

4 “(1) MAMMOGRAMS.—In the case of a female
5 participant or beneficiary who is 40 years of age or
6 older, or is under 40 years of age but is at high risk
7 (as defined in subsection (d)) of developing breast
8 cancer, an annual mammography (as defined in sec-
9 tion 1861(jj) of the Social Security Act) conducted
10 by a facility that has a certificate (or provisional cer-
11 tificate) issued under section 354 of the Public
12 Health Service Act.

13 “(2) CLINICAL BREAST EXAMINATIONS.—In the
14 case of a female participant or beneficiary who—

15 “(A)(i) is 40 years of age or older or (ii)
16 is at least 20 (but less than 40) years of age
17 and is at high risk of developing breast cancer,
18 an annual clinical breast examination; or

19 “(B) is at least 20, but less than 40, years
20 of age and who is not at high risk of developing
21 breast cancer, a clinical breast examination
22 each 3 years.

23 “(3) PAP TESTS AND PELVIC EXAMINATIONS.—
24 In the case of a female participant or beneficiary

1 who is 18 years of age or older, or who is under
2 18 years of age and is or has been sexually active—

3 “(A) an annual diagnostic laboratory test
4 (popularly known as a ‘pap smear’) consisting
5 of a routine exfoliative cytology test (Papani-
6 colaou test) provided to a woman for the pur-
7 pose of early detection of cervical or vaginal
8 cancer and including an interpretation by a
9 qualified health professional of the results of
10 the test; and

11 “(B) an annual pelvic examination.

12 “(4) COLORECTAL CANCER SCREENING PROCE-
13 DURES.—In the case of a participant or beneficiary
14 who is 50 years of age or older, or who is under 50
15 years of age and is at high risk of developing
16 colorectal cancer, all of the following procedures fur-
17 nished to the individual for the purpose of early de-
18 tection of colorectal cancer:

19 “(A) Screening fecal-occult blood test, but
20 not to exceed once every 12 months.

21 “(B) Screening flexible sigmoidoscopy, but
22 not to exceed once every 48 months.

23 “(C) In the case of an individual at high
24 risk for colorectal cancer, screening

1 colonoscopy, but not to exceed once every 24
2 months.

3 “(D) Such other tests or procedures, and
4 modifications to tests and procedures under this
5 paragraph, with such frequency, as the Sec-
6 retary of Health and Human Services deter-
7 mines appropriate, in consultation with appro-
8 priate organizations.

9 Under this paragraph, a screening barium enema
10 may be substituted either for a screening flexible
11 sigmoidoscopy or for a screen colonoscopy at the at-
12 tending physician’s discretion.

13 “(5) PROSTATE CANCER SCREENING.—In the
14 case of a participant or beneficiary who is 50 years
15 of age or older, an annual test consisting of any (or
16 all) of the procedures described in section
17 1861(o)(2) of Social Security Act (42 U.S.C.
18 1395x(o)(2)) provided for the purpose of early de-
19 tection of prostate cancer.

20 “(b) PROHIBITIONS.—A group health plan may not—

21 “(1) deny to an individual eligibility, or contin-
22 ued eligibility, to enroll or to renew coverage under
23 the terms of the plan, solely for the purpose of
24 avoiding the requirements of this section;

1 “(2) provide monetary payments or rebates to
2 individuals to encourage such individuals to accept
3 less than the minimum protections available under
4 this section;

5 “(3) penalize or otherwise reduce or limit the
6 reimbursement of a provider because such provider
7 provided care to an individual participant or bene-
8 ficiary in accordance with this section; or

9 “(4) provide incentives (monetary or otherwise)
10 to a provider to induce such provider to provide care
11 to an individual participant or beneficiary in a man-
12 ner inconsistent with this section.

13 “(c) RULES OF CONSTRUCTION.—

14 “(1) Nothing in this section shall be construed
15 to require an individual who is a participant or bene-
16 ficiary to undergo a procedure, examination, or test
17 described in subsection (a).

18 “(2) Nothing in this section shall be construed
19 as preventing a group health plan from imposing
20 deductibles, coinsurance, or other cost-sharing in re-
21 lation to benefits described in subsection (a) con-
22 sistent with such subsection, except that such coin-
23 surance or other cost-sharing shall not discriminate
24 on any basis related to the coverage required under
25 this section.

1 “(d) HIGH RISK DEFINED.—For purposes of this
2 section, an individual is considered to be at ‘high risk’ of
3 developing a particular type of cancer if, under guidelines
4 developed or recognized by the Secretary based upon sci-
5 entific evidence, the individual—

6 “(1) has one or more close family members who
7 have developed that type of cancer;

8 “(2) has previously had that type of cancer;

9 “(3) has the presence of an appropriate recog-
10 nized gene marker that is identified as putting the
11 individual at a higher risk of developing that type of
12 cancer; or

13 “(4) has other predisposing factors that signifi-
14 cantly increases the risk of the individual con-
15 tracting that type of cancer.

16 For purposes of this subsection, the term ‘type of cancer’
17 includes other types of cancer that the Secretary recog-
18 nizes as closely related for purposes of establishing risk.”.

19 (b) INDIVIDUAL HEALTH INSURANCE.—(1) Part B
20 of title XXVII of the Public Health Service Act is amend-
21 ed by inserting after section 2752 the following new sec-
22 tion:

1 **“SEC. 2753. STANDARD RELATING PATIENT FREEDOM OF**
2 **CHOICE.**

3 “(a) IN GENERAL.—The provisions of section 2707
4 (other than subsection (d)) shall apply to health insurance
5 coverage offered by a health insurance issuer in the indi-
6 vidual market with respect to an enrollee under such cov-
7 erage in the same manner as they apply to health insur-
8 ance coverage offered by a health insurance issuer in con-
9 nection with a group health plan in the small or large
10 group market to a participant or beneficiary in such plan.

11 “(b) NOTICE.—A health insurance issuer under this
12 part shall comply with the notice requirement under sec-
13 tion 714(d) of the Employee Retirement Income Security
14 Act of 1974 with respect to the requirements referred to
15 in subsection (a) as if such section applied to such issuer
16 and such issuer were a group health plan.”.

17 “(2) Section 2762(b)(2) of such Act (42 U.S.C.
18 300gg-62(b)(2)) is amended by striking “section 2751”
19 and inserting “sections 2751 and 2753”.

20 “(c) EFFECTIVE DATES.—(1) Subject to paragraph
21 (3), the amendments made by subsection (a) shall apply
22 with respect to group health plans for plan years begin-
23 ning on or after January 1, 2000.

24 “(2) The amendment made by subsection (b) shall
25 apply with respect to health insurance coverage offered,

1 sold, issued, renewed, in effect, or operated in the indi-
2 vidual market on or after such date.

3 (3) In the case of a group health plan maintained
4 pursuant to 1 or more collective bargaining agreements
5 between employee representatives and 1 or more employ-
6 ers ratified before the date of enactment of this Act, the
7 amendments made to subsection (a) shall not apply to
8 plan years beginning before the later of—

9 (A) the date on which the last collective bar-
10 gaining agreements relating to the plan terminates
11 (determined without regard to any extension thereof
12 agreed to after the date of enactment of this Act),
13 or

14 (B) January 1, 2000.

15 For purposes of subparagraph (A), any plan amendment
16 made pursuant to a collective bargaining agreement relat-
17 ing to the plan which amends the plan solely to conform
18 to any requirement added by subsection (a) shall not be
19 treated as a termination of such collective bargaining
20 agreement.

21 (d) COORDINATED REGULATIONS.—Section 104(1)
22 of Health Insurance Portability and Accountability Act of
23 1996 is amended by striking “this subtitle (and the
24 amendments made by this subtitle and section 401)” and
25 inserting “the provisions of part 7 of subtitle B of title

1 I of the Employee Retirement Income Security Act of
2 1974, the provisions of parts A and C of title XXVII of
3 the Public Health Service Act, and chapter 100 of the In-
4 ternal Revenue Code of 1986”.

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